YORKTOWN PHARMACY

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IMMUNIZATION SCREENING AND CONSENT FORM FOR MODERNA COVID-19 VACCINE

PATIENT INFORMATION *(Please print clearly)*

Last Name: **MI:**	**First Name:**	**D.O.B.:**	**Age:**	**Gender:**
Race/ Ethnicity:	American Indian/Alaska Native	Black/African American	Hispanic/Latino	
	Native Hawaiin/Other Pacific Islander	White	Asian	Other
Home Address:			Contact Phone:	
City:	State:		Zip:	
Primary Care Physician:			Physician Phone:	
Physician Address:			Physician Fax #:	
Patient's Covid-19 Vaccination Phase and Documentation:				

SCREENING QUESTIONNAIRE

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today. ***If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated.*** *It just means additional questions may be asked. If a question is not clear, please ask your healthcare provider to explain it.*

ALL VACCINES	Yes	No	Don't Know
1. Are you feeling sick today?			
2. Have you ever received a dose of COVID-19 vaccine?			
3. If yes, which vaccine product? **Pfizer** **Moderna** **Another product** _____			
3. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or EpiPen®, or for which you had to go to the hospital?			
• Was the severe allergic reaction after receiving a COVID-19 vaccine?			
• Was the severe allergic reaction after receiving another vaccine or another injectable medication?			
4. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			
5. Have you received another vaccine in the last 14 days?			
6. Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?			

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7. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?			
8. Do you have a bleeding disorder or are you taking a blood thinner?			
9. Are you pregnant or breastfeeding?			

I certify that I am: (a) the patient and at least 18 years of age or (b) the parent or legal guardian of the patient. Further, I hereby give my consent to the healthcare provider of Yorktown Pharmacy, to administer the vaccine(s) I have requested above. I understand the risks and benefits associated with the above vaccine(s) and have received, read and/or had explained to me the Vaccine Information Statements on the vaccine(s) I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless the applicable Provider, its staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine(s) listed above. I acknowledge that I understand the purposes/benefits of my state's immunization registry ("State Registry") and the Provider may disclose my immunization information to the State Registry. I acknowledge that, depending upon my state's law, I may prevent the disclosure of my immunization information by the applicable Provider to the State Registry by using the opt-out form. The Provider will, if my state permits, provide me with an Opt-Out Form. I understand that, depending on my state's law, I may need to specifically consent, and to the extent required by my state's law, by signing below, I hereby do consent to the Provider reporting my immunization information to the State Registry. I understand that even if I do not consent or if I withdraw my consent, my state's laws may permit certain disclosures of my immunization information as required or permitted by law. I voluntarily authorize and direct my healthcare provider at "Yorktown Pharmacy" to use or disclose my health information during the term of this Authorization to the physician responsible for this protocol of specific health information of people vaccinated at "Yorktown Pharmacy", my Primary Care Physician, my insurance and/or state or federal registries, where required, for the purpose of treatment, payment or other healthcare operations. I further agree to be fully financially responsible for any cost sharing amounts, including copays, coinsurance, and deductibles, for the requested items and services as well as for any requested items and services not covered by my insurance benefits. I understand that any payment for which I am financially responsible is due at the time of service.

PATIENT NAME:_____
(Please print clearly)

PATIENT SIGNATURE:_____ **DATE:**_____
(Parent or guardian, if minor)

PHARMACY USE ONLY VACCINE(S) GIVEN

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PHARMACIST/INTERN SIGNATURE:_____

ADMINISTRATION DATE:_____ **DATE VIS GIVEN TO PATIENT:**_____